Questions and Answers on Chapter 78, P.L. 2011, Senate #2937
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Relying on Publicly Available Information and Counsel

These questions and answers were prepared to assist clients in the implementation of the new law. These questions have been submitted by clients for our consideration. All public entities must rely solely on the advice of counsel regarding these issues and its implications. This information is offered as a starting point and may be modified or clarified as issues are defined more exactly based upon development of legal opinions, additional legislation, and regulatory action. This information is in no way intended to represent legal advice or guidance. The source of the explanations herein is based solely on our review of publicly available materials and a reasonable interpretation of the law as published by the state.

A Q&A issued by the NJ Division of Pensions and Benefits is helpful and can be reviewed as an introduction to Chapter 78. A link to the Q&A is:

http://www.nj.gov/treasury/pensions/reform-hb-qa.shtml

The law itself is available at:

http://www.nj.gov/treasury/pensions/pdf/laws/chapt78-2011.pdf

Questions and Answers:

1. How is base salary defined?

Answer:

Base salary is not specifically defined by the Act. However, the State has determined that "the calculation is based on the employee's base contractual salary. In most instances, that means the salary on which pension contributions are based. However, for employees hired after July of 2007 for whom pensionable salary is limited to the salary on which Social Security contributions are based, the employee's total base salary would be used. As an employee receives salary increases during the year, the amount of contribution will be adjusted upwards accordingly." See Q & A at question 4;
http://www.nj.gov/treasury/pensions/reform-hb-qa.shtml

2. Do non-State Health Benefit Plan / State Education Health Benefits Plan (SHBP / SEHBP) participants need to collect contributions for vision and dental coverage?

Answer:

The bill does require non-SHBP/SEHBP participating employers to include vision and dental premium costs as the total "cost of coverage." The bill states as follows:

"Base salary shall be used to determine what an employee earns for the purposes of this provision. As used in this section, "cost of coverage" means the premium or periodic charges for medical and prescription drug plan coverage, but not for dental, vision, or other health care, provided under the State Health Benefits Program or the School Employees' Health Benefits Program; or the premium or periodic charges for health care, prescription drug, dental, and vision benefits, and for any other health care benefit, provided pursuant to P.L.1979, c.391 (C.18A:16-12 et seq.), N.J.S.40A:10-16 et seq., or any other law by a local board of education, local unit or agency thereof, and including a county college, an independent State authority as defined in section 43 of P.L. , c. (C.) (pending before the Legislature as this bill), and a local authority as defined in section 44 of P.L. , c. (C.) (pending before the Legislature as this bill), when the employer is not a participant in the State Health Benefits Program or the School Employees' Health Benefits Program."

3. If one's medical plan is in the SHBP or SEHBP and Rx is not, does the contribution apply to dental and vision?

Answer:

No.

4. Do Boards of Education and local units have the ability to substitute the contribution schedule with other economically equivalent cost savings?

Answer:

Yes. Boards of Education and units of Local Government that do not participate in the SHBP/SEHBP may enter into contracts for health care benefits coverage, as may be required to implement a collective negotiations agreement, and agree to different employee contribution rates if certain cost savings in the aggregate over the period of the agreement can be demonstrated. The savings must be certified to the Division of Pensions and Benefits, and the Department of Education or the Department of Community Affairs, as appropriate.

The Department of Education or the Department of Community Affairs is to approve or reject the certification, within 30 days of receipt. The certification is deemed to be approved if not rejected within that time. The agreement cannot be executed until that approval is received or the 30-day period has lapsed, whichever occurs first. See Q & A, question 6, at: http://www.state.nj.us/treasury/pensions/reform-hb-qa.shtml

5. The legislation indicates the provided percentages of premium are a minimum requirement. Is this in aggregate or for each salary band? Do entities not in the State plan have the flexibility to collapse salary bands as long as they achieve the minimum aggregate contribution level?

Answer:

Yes. Units of Local Government that do not participate in the SHBP/SEHBP may enter into contracts for health care benefits coverage, as may be required to implement a collective negotiations agreement, and agree to different employee contribution rates if certain cost savings in the aggregate over the period of the agreement can be demonstrated. The savings must be certified to the Division of Pensions and Benefits, and the Department of Education or the Department of Community Affairs, as appropriate. The Department of Education or the Department of Community Affairs are to approve or reject the certification, within 30 days of receipt. The certification is deemed approved if not rejected within that time. The agreement cannot be executed until that approval is received or the 30-day period has lapsed, whichever occurs first. See Q & A, question 6, at: http://www.state.nj.us/treasury/pensions/reform-hb-qa.shtml

6. If you deviate from the published contribution schedule it is unclear as to how the approving agencies will evaluate the calculation. Will there be guidelines issued regarding the type of illustrations?

Answer:

The new legislation does not set forth guidelines and appears to leave it up to the approving agency to establish its own guidelines.

7. It appears that a new employee does not use the phase in schedule, but is subject to the "year 4" contribution schedule. If that is correct, what constitutes a new employee? For example, if an employee switches school districts, are they a new employee? Or are they new if they are new to the pension system?

Answer:

The law does not define new employee. However, if an employee changes public employers, it would be reasonable to assume that the employee would be responsible for the full premium contribution upon beginning with the new employer.

8. The law requires that the full contribution be required of new employees. Does this hold even if they new employee is covered by a collective bargaining agreement which has not yet expired?

Answer:

According to the Local Finance Notice issued by the NJ Department of Community Affairs, for new employees whose positions are covered by an existing CNA in effect on June 28, 2011, and begin work on or after the effective date; they are covered by the contract and their contribution commences upon expiration of the CNA, at which time the four-year phase begins. They are treated the same as employees who are already employed and covered by a CNA.

9. When do contributions start for non-union employees that have a written employment contract of their own?

Answer:

Contributions would start upon the expiration of the employment contract.

10. The law allows contributions to be reduced when cost savings from alternative arrangements are demonstrated. Can this alternative savings approach also be applied to new employees or will new employees pay the higher contributions regardless?

Answer:

Yes. The new employee will be required to pay the premium rate at "stage 4" when hired, but if that alternative arrangement (beginning at stage 4) can be demonstrated, there is nothing that would prohibit such action, but it must be approved by the State.

11. If an in-force CBA is re-opened for any purpose, the contribution terms shall have to be applied and take effect as well. Is this accurate?

Answer:

Yes.

12. The contribution schedule does not take full effect on "day one". It is imposed on an incremental basis. First year is ¼, 2nd year is ½, 3rd year is ¾ and presumably the 4th year is on full. The language stops at the 3rd year of the schedule so upon the 4th year is it in fact 100% of the 4th year's amounts? Is this accurate?

Answer:

Yes. See Q & A, question 2, at: http://www.state.nj.us/treasury/pensions/reform-hb-qa.shtml

13. For retirees, their contribution shall be based upon the "withholding of contributions from the monthly retirement allowance". Is this accurate?

Answer:

Retiree contributions toward their health care premiums are based on the "percentage applicable to the range within which the annual retirement allowance and any future cost of living adjustments thereto falls." Just like current employees' whose premium contributions are based on their salaries, future retiree premium contributions will be based on the amount of money the retiree is collecting from his/her pension. The same chart used to determine employee premium contributions is used to determine the retiree premium contribution. The premium contribution is withheld from the monthly pension payment for the retiree. This section does not cover current retirees or current employees with 20 or more years of credited service.

14. How does the law impact current retirees, those with 20+ years of service credits, and those with less than 20 years of service credits as of the effective date of Chapter 78?

Answer:

- For current retirees, no contribution is required.
- For current employees with service credit of 20+ years as of June 28, 2011, no contribution will be required upon retirement.
- Future retirees with less than 20 years of service credit as of June 28, 2011 will pay based upon the contribution schedule or 1.5% of pension, whichever is greater.
- Prior to retirement, active employees with either 20 or 25 years of service credit are subject to the same contribution requirements as other employees.

15. Is it true that the final law excludes any differentiation in benefits provided by out of State providers?

Answer:
Yes.

16. It appears that the schedule of contributions shall serve as the "starting point" for any new agreement entered into among parties after the expiration of any new agreement that takes effect immediately after the passage of the law. Is that accurate?

Answer:
Yes. "The public employers and public employees will remain bound by the health care contribution provisions of the law, notwithstanding the expiration of those sections, until the full amount of the contribution has been implemented in accordance with the schedule set forth in this law.

Employees subject to any collective negotiations agreement in effect on the effective date of the law, that has an expiration date on or after the expiration of the health care contribution provisions of the law, will be subject to those provisions, upon expiration of that collective negotiations agreement, until the health care contribution schedule set forth in the law is fully implemented.

After full implementation, those contribution levels will become part of the parties' collective negotiations and will then be subject to collective negotiations in a manner similar to other negotiable items between the parties." See http://www.nj.gov/treasury/pensions/newlaw11.shtml#chap78

17. The langague provides for the flexibility to install the new cost sharing provisions as soon as administratively possible and an entity cannot go back retroactively to the date of the law if it took the 6 monhs to get ready. Is this accurate?

Answer:
The law requires that the administrative process for implementation begin upon the signing of the bill. It contemplates a delay between the administrative process and the actual implemenation and does not allow employers to make retroactive deductions to the effective date of the bill. However, employers should begin the administration of implementing the bill as soon as possible. The State anticipates having all State employee deductions begin in October of 2011.

18. Upon a review of the law, there is reference to having to offer three options for the state plans but no specific reference is found for local entities not participating in the state plan having to offer three options. Does that requirement apply to the local entities not in the state plan?

Answer:

The legislation does not appear to require entities not in SHBP or SEHBP to offer three options. The law contemplates differences in the types of coverages offered by employers not in SHBP or SEHBP by including the language "or its equivalent" to describe various types of coverage. Employers not in SHBP or SEHBP must determine how the coverages they offer correlate to the coverages offered by the State to determine which percentage of premium contribution is required for its employees.

19. Do entities need to provide three dental and three pharmacy plans in addition to three medical plans?

Answer:

The new legislation does not appear to require three dental or pharmacy plans.

20. How does the benefit contribution sunset provision of the requirements apply to a contract that expires in the future? For example, if a contract expires on 12/31/2013, does the mandate sunset on 12/31/2017 or 4 years from the effective date of the law?

Answer:

Employees subject to any collective negotiations agreement in effect on the effective date of the law, that has an expiration date on or after the expiration of the health care contribution provisions of the law, will be subject to those provisions, upon expiration of that collective negotiations agreement, until the health care contribution schedule set forth in the law is fully implemented. See http://www.nj.gov/treasury/pensions/newlaw11.shtml#chap78

Thus, it appears employees will be required to pay the full amount of premium contributions, even though the law could sunset prior to the employees reaching the full contribution amount.

21. If a CBA expires in 2013, at that time do we execute the "year three" column of the phase-in schedule or do we start from year one?

Answer:

Upon the expiration of the CBA, the employer begins at year 1 of the phase-in schedule. "Employees currently under a collective negotiations agreement will not be impacted by the changes described above until the agreement expires. Upon expiration, employees covered by that agreement, will begin at year 1 of the phase-in until they reach year 4 of the phase-in." See Q & A at Question 2: http://www.nj.gov/treasury/pensions/reform-hb-qa.shtml

22. We currently use a 4-tier rate structure; single, husband/wife, parent/child(ren) and family. The law's new contribution schedule only references a 3-tier rate. Is the 3 tier structure in the law for contributions only or does it also guide coverage tiers? Can a 4-tier coverage system co-exist with a 3-tier contributions structure? Are we allowed to use the 4-tier structure now in place? If so, what rules and guidance will be offered as to how we can set the husband/wife and parent/child(ren) rates? Although rare, some clients also have 1, 2 and 5 tier plans. What are the implications of this?

Answer:

State Health Benefits Plan provides coverage for Parent / Child(ren), which is a separate coverage than family coverage. The premium increases with the amount of dependent children added to the plan. Since the legislation states "for member with child or spouse or its equivalent" the recently passed health care legislation setting forth premium contributions for parent/child it should be read to incorporate parent/child(ren) Therefore, a single parent with more than one child would qualify for the parent/child(ren) plan under SHBP or a private insurance and be subject to the parent/child premium contribution rate set forth in the recently passed legislation as opposed to the family premium contribution rate.

23. It appears that every entity must have a Section 125 plan for both premium conversion and unreimbursed medical, but not for dependent care. Is that accurate or do we also now have to offer a Dependent Care Account Plan as well?

Answer:

An employer may offer dependent care expenses. However, it is mandatory that the employer establish a 125 plan for medical or dental expenses not covered by health benefits plan. See Chapter 78, P.L. 2011, Senate #2937, at pg 99, lines 18-40. The mandatory reimbursement for medical care provides for reimbursement for all medical and dental expenses for all family members covered under the employee's health care plan.

24. Can someone be paid for the cost of their employee payroll contribution from the FSA account or just expenses like copayments, deductibles, etc?

Answer:

No.

25. Are there any populations or instances where the full contribution schedule can be installed as opposed to percentages of it?

Answer:

The full contribution schedule can be imposed for employees hired after the effective date of the legislation.

26. 1.5% of Base Salary will be used as a floor/minimum for the contribution amount. Is this base salary as of one point in time (for example, the base salary as of the date of open enrollment each year)? What happens if a person gets a raise/promotion in the middle of a plan year? Could the contribution then change in the middle of the plan year as well or is it frozen for the year?

Answer:

Yes. "As an employee receives salary increases during the year, the amount of contribution will be adjusted upwards accordingly." See Q & A at question 4; http://www.nj.gov/treasury/pensions/reform-hb-qa.shtml

27. Does the 1.5% apply to medical and drug combined? Can someone choose medical only coverage?

Answer:

The 1.5% applies to an employee's base salary, regardless of the level of coverage the employee maintains. If 1.5% of the employee's base salary is greater than the percentage of health care premiums paid on behalf of that employee, the employee will be responsible for 1.5% of base salary as opposed to the applicable percentage of premium.

28. The law provides percentages to apply to the premium. For a self insured group in the public sector does it specify what must be included in that number? Are fixed costs professional service provider compensation amounts required to be included?

Answer:

The legislation only requires that the employee pay a percentage of the health care premium that it costs to cover that employee based on the coverage that employee selects and base salary of that employee. If fixed costs and broker/consultant commissions are built into each employee's cost of premium, then the employee would pay on those costs.

29. Is the FSA for unreimbursed medical and dependent care optional or mandatory?

Answer:

An employer may offer dependent care expenses. However, it is mandatory that the employer establish a 125 plan for medical or dental expenses not covered by health benefits plan. See Chapter 78, P.L. 2011, Senate #2937, at pg 99, lines 18-40. The mandatory reimbursement for medical care provides for reimbursement for all medical and dental expenses for all family members covered under the employee's health care plan.

30. For the state workers benefit plan there shall be a new committee of 12 on a Benefit Plan Design Committee. This does not impact local entities. This committee shall have power to make, change or alter the benefits for the state plans. It is unclear if this replaces bargaining for benefits or not. Please explain.

Answer:

The statute appears to give the Benefit Plan Design Committee as well as the State Health Benefits Commission the power to unilaterally make, change or alter the benefits for state workers without having to collectively bargain.

31. Regarding the SEHBP Plan Design Committee, it appears the committee shall have power to make, change or alter the benefits for the SEHBP. It is unclear if this replaces bargaining for benefits or not. Is this the case?

Answer:

The statute appears to give the SEHBP Plan Design Committee, like the SHBP Design Committee the power to unilaterally make, change or alter the benefits for state workers without having to collectively bargain.

32. There will be a new SEHBP board. Does this mean that the current board is abolished now?

Answer:

It is unclear from the legislation if the SEHBP Commission is being replaced or abolished by the SEHBP committee.

33. Language in the statute includes references to lifetime and other maximums that may no longer be allowable under the federal Patient Protection and Affordability Act. Which law would prevail?

Answer:

To the extent the Act is incompatible with Federal law, Federal law should be followed.

34. For state workers, the state must offer three plan options. It is unclear if these three new plans will replace what is currently offered to state workers or will be in addition to them. Please explain.

Answer

It is unclear if the new plans will replace the current options; however we anticipate the new options to replace existing plans. We will not know for sure though what the new plans will entail until the plans are established.

35. For the SEHBP, the language says that the Benefits Plan Design Committee shall provide the "option" to select one of three coverages, etc. It is unclear if these three new plans will replace what is currently offered to state workers or will be in addition to them. Do they replace or become added upon? Do the new options have to be in place by 1/1/2012?

Answer:

See answer to number 36.

36. The language for the SEHBP appears to spell out the current benefit options and says they are the plans. Do these plans go away when the three options are added or do they remain intact so that employees in the SEHBP can select them too?

Answer:

Until the new health care plans are established it is unclear what will become of the existing plans.

37. Regarding all state plans, if the Plan Design Committees do not come to agreement on suggested changes to the full Committees of the state plans, then an arbitrator from the NJ PERC shall be engaged to assist. According to the law, it seems that the arbitrator shall not have the power to impose a decision if one cannot be agreed upon. If they do not reach agreement the arbitrator shall make a report with 10 days to the public and the committee. It appears there is no final resolution process when there is a deadlock. Is this the case?

Answer:

Yes. The law offers no additional details about what happens.

38. Within one year from passage of the law the Treasury has to issue a report on the long term sustainability of the state plans, issuing a report and recommendations to the Governor. It is unclear who will participate in the study, how it will be conducted, by whom and using what approach and methodology. Is this determined solely by the state Treasurer?

Answer:

The legislation provides for only the Division of Pension and Benefits in the Department of the Treasury to conduct a study of: the risk impact of permitting employers to commence and to terminate participation in SHBP and SEHBP; the long term sustainability of the programs; employee wellness programs; options for out-of-network cost containment; and the impact on the programs of this legislation. The Department of Treasury must submit the report to the Governor and the Legislature.

39. For the state health benefit plan (not the SEHBP), does the new board managing that now have jurisdiction over state workers and all non-school related entities? Who makes the decisions impact non-school local entities participating in the State plan?

Answer:

The legislation provides that, "The Committee shall have the responsibility for and authority over the various plans and components of those plans, including for medical benefits, prescription benefits, dental, vision and any other health care benefits, offered and administered by the program. The committee shall have the authority to create, modify, or terminate any plan or component, at its sole discretion." See Chapter 78, P.L. 2011, Senate #2937, at pg 85, lines 1-6. Thus, it appears the legislation provides the Committee with authority over SHBP and any participating employer.

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